CANADA BUILDING
DENTAL GROUP

308 – 105 21st St E, Saskatoon, SK S7K 0B3
ph: 306.665.1986 e: info@canadabuildingdentalgroup.com
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Welcome to Our Office Date: _____

Your medical history is very important to us. In order for us to provide you with the best possible dental services, please answer all questions completely and accurately as incorrect information may compromise your treatment. This Medical History Form will become a part of your dental treatment record and is considered confidential.

Patient Information

Last Name_____ First Name _____

Address _____

City_____ Province_____ Postal Code_____

Phone (___)_____ Cell (___)_____ Email_____

Birth Date_____ Occupation _____

Do you have dental insurance? (circle) ☐ Yes ☐ No Health Card #_____

How did you hear about us? _____

Dental History

1. What is the reason for today's visit ☐ Emergency ☐ Examination Other_____
2. How frequently do you see a Dentist ☐ 3 months ☐ 6 months ☐ 9 months ☐ Annually
3. When was your last dental visit?_____ Last X-Ray?_____
4. How often do you brush per day?_____ Floss?_____
5. Are your teeth sensitive to (check all that apply) ☐ Sweets ☐ Cold ☐ Heat ☐ Pressure
6. Do your gums bleed when (check all that apply) ☐ Brushing ☐ Flossing ☐ Never
7. Have you ever been told you have bad breath? (check) ☐ Yes ☐ No
8. Have you ever had any pain in your jaw joint? (clicking, popping)(check) ☐ Yes ☐ No
9. Are your teeth loose? (check) ☐ Yes ☐ No
10. Do you grind or clench your teeth? (check) ☐ Yes ☐ No
11. Does food catch between your teeth? (check) ☐ Yes ☐ No
12. Have you ever had local anesthetic (freezing)? (check) ☐ Yes ☐ No
    Any complications? ☐ Yes ☐ No Specify_____
13. Have you ever had any problems with previous dental treatments? (check) ☐ Yes ☐ No
    Specify_____
14. Are you happy with your smile/satisfied with your teeth? (check) ☐ Yes ☐ No
    If no, please explain:_____
15. What would you change about the present condition of your mouth? _____
    _____

Medical History

1. Are you currently under the care of a physician? (check) ☐ Yes ☐ No
   Physician Name:_____ Phone #:(___)_____
   Reason for last visit?_____Date:_____
2. Have you ever had a serious illness, operation, or been hospitalized? (check) ☐ Yes ☐ No
   If so, please explain:_____
3. Has there been any change in your health in the last (2) years? (check) ☐ Yes ☐ No
   If so, please explain:_____
4. Have you ever had an allergic reaction? To: (check) ☐ Medication ☐ Food ☐ Latex Products
   Other:_____
5. Have you ever been treated for: (check all that apply)

☐ Heart attack	☐ Bleeding/clotting	☐ Venereal disease	☐ Arthritis/Rheumatism
☐ Heart surgery	☐ Ulcers	☐ AIDS	☐ Cortisone medication
☐ Chest pain	☐ Diabetes 1 / 2	☐ HIV positive	☐ Diet restriction
☐ Congenital heart disease	☐ Thyroid low / high	☐ Cold sores	☐ Artificial joints
☐ Heart murmur	☐ Glaucoma	☐ Blood transfusion	☐ Kidney trouble
☐ Blood pressure low / high	☐ Emphysema	☐ Hemophilia	☐ Cancer
☐ Mitral valve prolapse	☐ Chronic cough	☐ Sickle cell disease	☐ Radiation therapy
☐ Artificial heart valve	☐ Tuberculosis	☐ Bruise easily	☐ Chemotherapy
☐ Heart pacemaker	☐ Asthma	☐ Neurological disorders	☐ Tumors
☐ Rheumatic fever	☐ Hay fever	☐ Epilepsy or Seizures	☐ Psychiatric/psychological care
☐ Stroke	☐ Latex sensitivity	☐ Fainting or dizziness	☐ Liver disease
☐ Swollen ankles	☐ Allergies or hives	☐ Osteoporosis	☐ Hepatitis A B C
☐ Anxiety	☐ Sinus trouble	☐ Bisphosphonate medication	☐ Yellow Jaundice

6. Do you now or have you ever used tobacco? (check one) ☐ Yes ☐ No
7. For women: a. Are you pregnant or do you think you may be pregnant? (check one) ☐ Yes ☐ No
   b. Are you taking birth control pills? (check one) ☐ Yes ☐ No

Current Medication(s): Prescribed and Over-the-Counter

	Name of Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			

Emergency contact information

Name _____ Relationship _____
Phone (____)_____

Patient Signature_____ Date_____
If you have completed this form for another person, please print your name and sign below along with your relationship to the patient.

Print_____ Relationship_____

Signature_____ Date_____

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Consent for Dental Treatment

This is to certify that I consent to performing of dental procedures agreed to be necessary or advisable, including the use of local anesthetic. I understand that any treatment needed will be fully discussed with me by the dentist prior to the beginning of treatment, including all treatment options. I understand that no treatment is always an option. I also understand that any treatment done, including but not limited to, fillings and crowns, while intended to save the tooth, may result in tooth death, which may further result in the need for a root canal or extraction. I will also assume responsibility for the fees associated with all dental procedures performed.

Consent for Collection and Release of Information

Contact Information

We are committed to protecting the privacy of our patients` personal information. We collect contact information from our patients for the purposes of opening / updating patient files, to confirm dental appointments, send recall notices, and collect payment for outstanding balances owing.

Medical Information

We collect medical information for the purpose of diagnosing and providing responsible and informed dental treatment. This information may be disclosed to third party health benefit providers and insurance companies, other dentists or dental specialists, or physicians or other medical specialists as deemed appropriate by the dentist for the purposes of consultation or referrals.

Dental History

We collect dental history so our office can provide continuing dental treatment for the patient, as well as for possible consultation or referral to dental specialists if needed. We may request past dental records, including radiographs, be forwarded to our office from previous dentists.

Payment of Fees and Insurance Submission

We send dental insurance claims to participating insurance companies electronically on your behalf. If your dental plan does not cover the full cost of your treatment, you are responsible for any difference between the amount paid by your plan and the amount charged. Your portion is due and payable the day of your appointment. Please note that it is your responsibility to provide us with all the necessary information in order for us to direct bill your insurance company as well as informing us of any changes to this information.

Office Policies

1. We require a minimum of 24 hours notice to cancel OR change any appointment. A College of Dental Surgeons of Saskatchewan standard fee will be charged if an appointment is missed or cancelled without sufficient notice.
2. We offer a reminder call two days before your appointment. Please note that this is a courtesy call. If you do not receive our call and/or message, you are responsible for the appointment that you scheduled.
3. After 3 appointments are missed or cancelled without sufficient notice, we will no longer be able to schedule your appointments at our office.
4. New patient / initial visit – you are responsible for treatment costs. Insurance forms will be provided for you to submit for reimbursement. Subsequent visits – our office provides electronic / manual billing to insurance companies on your behalf. Due to the privacy act, you are responsible to monitor your plan's coverage and maximums. If your insurance does not cover your treatment, you are responsible to cover the cost.

I have read and I agree to these policies of Canada Building Dental Group.

Signature of patient, parent or guardian	Print Name	Date